Illinois Department of Healthcare and Family Services

FAX TO: (217) 524-7264
(217) 524-0404

REQUEST FOR DRUG PRIOR APPROVAL

NOTE: Please print legibly and include all info requested. Incomplete forms cannot be accepted and may result in a delay in review by pharmacy staff.

Patient 9 Digit Recipient ID Number _____

Patient Name _____ **DOB** _____

LTC Facility (if applicable) _____

Physician DEA or State License # _____

Physician Name _____ **Phone** _____

Address _____

City, Zip _____

Pharmacy 12 Digit Provider Number _____

Pharmacy Name _____ **Phone** _____

Address _____

City, Zip _____

Effective Begin Date _____

Diagnosis or ICD-9 Code _____

Drugs Previously Used for this Diagnosis _____

_____

_____

Reason for Requesting this Drug _____

_____

_____

Drug Requested _____ **NDC#** _____
(include strength/dosage form)

FOR PRIOR APPROVAL REQUESTS TO EXCEED MAXIMUM QTY:

Quantity to be dispensed _____ Directions _____

Requested by _____ Date _____
(Signature)

NOTE: Requests for drug approval will not be backdated earlier than three months from the date of postmark of the provider's request. Requests over three months must be accompanied with proper documentation as specified in manual.